MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, November 15, 2001
10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Payment for outpatient pain management procedures
Nancy Ray, Kevin Hayes

AFTERNOON SESSION [2:12 p.m.]

MR. HACKBARTH: The next item on our agenda is payment for outpatient pain management procedures. Nancy and Kevin.

MS. RAY: Good afternoon. This study is in response to a Congressional mandate in BIPA that MedPAC examine whether Medicare imposed barriers on the provision of interventional pain management procedures in physicians, offices, hospital outpatient departments, and ambulatory surgery centers. In the statute, the Congress explicitly asked us to examine whether there was variation in payment across these ambulatory settings.

This study is due in December. We are looking for the Commission to comment on our draft letter to the Congress on our five draft recommendations.

To help inform the Commission on this topic, we contracted with Project HOPE to review the literature, to look at Medicare's coverage and payment policies concerning interventional pain services, and to interview interested parties. A draft report from Project HOPE was included in your mailing materials. This is the same draft report you saw last time. They are still in the process of making changes to it. You will see it in its final form and then you will, of course, have opportunities to comment on that.

In your mailing materials, in our response to the Congress we included an appendix what are interventional pain procedures. We define them as minimally invasive procedures such as injection of drugs in targeted areas, ablation of targeted nerves, and certain surgical techniques that includes diskectomy, implanting, infusion pumps and spinal cord stimulators.

This recommendation, draft recommendation one, addresses the issue that we did find large differences in the payment rates for many types of services, including interventional pain services across ambulatory settings. Payment in ASCs are generally higher than those in other settings while physician practice expenses are lower.

Some of this variation may reflect differences in the underlying cost structures across these different ambulatory settings. In addition, some of this variation may also reflect the different basis for payment across these settings.

The concern here, however, is that such variations in payment could lead to shifting of care to inappropriate settings. If care is shifted among settings, it should occur for clinical reasons and not because of payment reasons.

So draft recommendation one actually reiterates a MedPAC recommendation that we made back in March of 1999, saying that the Secretary should evaluate payments for services provided in hospital outpatient departments, ASCs, and physicians' offices to ensure that financial incentives do not inappropriately affect

decisions regarding where car is provided.

Onto draft recommendation two. This recommendation addresses the issue that ASC payment policies are somewhat dated and this may be contributing to the inconsistency in payment across ambulatory settings. ASC payment rates are probably not consistent with their costs because the rates are based on old charge and cost data from the late 1980s. CMS is statutorily required to conduct a new rate survey every five years.

Another concern that we noted in our letter is that the list of procedures that are paid for when performed in ASCs has not been updated since 1998. Again, the concern is new procedures come out, new medical advances come out. CMS is not updating the list. CMS is statutorily required to review the list at least every two years. So draft recommendation two addresses these issues by recommending that the Secretary should evaluate rate for ASCs using recent charge and cost data, and that he should also update the list of procedures that are covered when performed in ASCs.

Draft recommendation three. This recommendation addresses the issue concerning the adequacy of the practice expense allocation for physicians that are performing interventional pain procedures. Our analysis found that, in general, the practice expense payments are lower compared with the facility payments to hospital outpatient departments and ASCs. We do not know if payments are adequate or not adequate because data on the costs of providing these procedures in office settings is lacking.

Of concern, however, is that beneficiaries' access to high quality care in office settings could be adversely affected if payment amounts are not adequate.

Physician practice allocation is a function of the practice expense of the physician specialties who perform a particular service and the mix of physician specialties who perform these services. With respect to interventional pain procedures, from the best that we can tell, a wide variety of physician specialties perform these services, including anesthesiologists, neurologists, physicians specializing in physical medicine.

The practice expense per hour data that is from the AMA survey for those specialties varies -- there's great variation, anywhere from about $27 for anesthesiologists to $88 for physicians specializing in physical medicine.

CMS will begin to recognize pain management as a specialty in January 2002. At issue is whether this new specialty will affect the adequacy of the practice expense allocation for interventional pain services. We have no way to ascertain how this new specialty designation will affect payment adequacy until data becomes available on the practice expenses of the physicians who will come forward and identify themselves under this new specialty designation and two, the mix of physician specialties who will ultimately perform these services.

This led us to draft recommendation three, that the Secretary should recalculate the practice expense payments for

interventional pain procedures when data become available on the practice expenses of physicians specializing in pain management.

Now we note in our response that if it appears that the practice expense allocation is not affected by this new specialty designation then the agency should consider other means to address this issue that potentially the practice expense allocation may not be adequate.

Onto draft recommendation four. This recommendation addresses our finding that inconsistencies in coverage policies occur across localities. Again, we've already spoken a lot about this issue in David's session on regulatory complexity, but there are many Medicare contractors who implement local coverage policies, the FIs, the carriers, and the DMERCs. They each can set policies within a given specified geographic area.

I did note in our response to the Congress that the variation in local coverage policies does exist despite efforts by CMS that requires its contractors to develop LMRPs that are evidence based, to establish an open and public process for developing LMRPs and to share information among one another.

MedPAC's and Project Hope's review of the medical literature suggest that there are limited number of randomized control studies evaluating interventional pain procedures. This may be hindering the ability of Medicare's contractors to establish policies in this clinical area.

Why we're concerned about this is this disparity in local coverage decisions is affecting access to certain interventional pain procedures. For example, several characters have issued different LMRPs about the number of facet joint blocks that can be provided during an encounter and the indication for which this procedure may be performed. This led us to draft recommendation four, which recommends that the Secretary sponsor additional research about the effectiveness of these services to strengthen the evidence bases for Medicare's coverage decisions.

We talked about two ways in the response to the Congress about how the Secretary could do that, including using provisional coverage as one way to further research. In doing so, they would be able to collect outcomes data and make a better informed evidence based decision about these services.

The other vehicle that we also include in our response is that the Secretary could pursue clinical research with NIH. Right now NIH and CMS are trying to get a daily dialysis clinical trial off the ground. We cited that as an example.

The last recommendation, recommendation five, reiterates our recommendation that we have made in the regulatory complexity analysis. That is ultimately the Commission believes that CMS should move to a standard nationwide system of claims processing, which would basically eliminate LMRPs and require that nationwide decisions be made about the coverage of medical services.

This recommendation, however, I don't think diminishes the need for the fourth recommendation because we still need

additional information about the effectiveness of interventional pain services in order for whoever is going to be making these decisions to make evidence based decisions.

That's it.

DR. LOOP: I thought this was well done. I've got a couple of editorial points. On page two, the two bullets, the first and third bullet could probably be combined. You don't need to comment on that now, but just think about it.

There's also, in the second bullet on page two, you comment that the delay in variation payment may adversely affect beneficiary access to care. I don't think there's any evidence of that. If there is, tell me. But before you answer it, let me tell you one other thing that relates to access to care.

On page four, at the bottom of four, you said despite variation in payment across ambulatory settings you didn't find access had been compromised. And then in the middle of page four you said Medicare policies for ASCs may be adversely affecting beneficiary access.

MS. RAY: You're right. We will go back and try to be consistent about that. You were right, we found hard evidence that access is, in any way, being compromised.

DR. LOOP: I would eliminate recommendation five, since we already addressed it.

DR. NEWHOUSE: This is not exactly the question the Congress asked, but it's related and I'd like anybody's view, particularly Carol's.

In this little study we did of hospice, which we referred to in the hospice, we found anecdotal reports when we went out in the field that access to the high end pain meds was a problem given hospice reimbursement. That is what we talk about payment variation across ambulatory sites. And since a lot of it is in the home, that's an ambulatory site.

I'm just wondering if we should have a recommendation that the Secretary should investigate whether there are problems on the hospice front.

DR. ROWE: Let me comment on that. I think at least one study I'm aware of demonstrated that in areas which were disadvantaged, particularly urban disadvantaged areas, there was very limited access to pain medication for individuals who really needed it. And it was because, in part at least, the pharmacies were not stocking substantial amounts of these medications because they were afraid of theft and getting broken into, et cetera, et cetera.

So in fact, in one study in New York that I'm aware of, that was a significant problem.

DR. NEWHOUSE: Of course, it will only be part of Medicare through hospice.

DR. ROWE: It probably wouldn't be through hospice unless the hospices were located in certain areas.

DR. NEWHOUSE: I mean it's not covered otherwise.

DR. ROWE: Oh, it's not covered. But the pain medicines

that we're talking about here are injectables which are given by physicians in their office or in a facility, not something -- so these would be covered, is my point. They're not something that would be in a pharmacy.

DR. NEWHOUSE: But on the hospice side they are covered.

DR. ROWE: With respect to this, I thought this was interesting and well done. I'll reiterate the comment I made last month. I'm surprised there's not an access problem. I'm delighted but I'm surprised because I see this as a very heterogeneous specialty that's just developing. And some cities have really good pain clinics, some hospitals have really good pain programs. Others you can't seem to find one.

So I'm surprised but I'm just wondering whether that means that we're lumping different kinds of pain treatment capacities together when they really aren't as robust as they might seem from these data. That's just my personal experience, but it's an anecdote. Floyd's laughing, he probably has the same anecdote, but the plural of anecdote is not data, so we're not going to go there.

The other thing I would say is it says here that Medicare is going to recognize this as a specialty soon and then it talks about the 3,000 anesthesiologists that have some sort of certificate of added qualification after their board certification.

I just want to make sure that there are other physicians besides anesthesiologists, neurologists, physiatrists and many others, neurosurgeons, orthopedics I can imagine, who perform this kind of a very important and valuable service to Medicare beneficiaries on a regular basis. And so I want to make sure we don't get into some compensation system where some groups of physicians are disadvantaged because they don't have some credential but they would be perfectly able and capable of providing this service in their office and should get compensated for it.

It doesn't say that here, but I just want to make sure that that's not the intent.

MS. RAY: That was not the intent. I just put that in as an example to show that the anesthesiologists did certify pain management as a subspecialty. It's my understanding that when a physician comes forward and identifies himself under a specialty that -- you know, a neurologist could come and identify himself as a pain management specialist. He does not have to be certified by any one group.

MS. RAPHAEL: Just a clarifying point. I agree with what Joe has said, because within hospice one of the most serious issues is how to manage the cost of pharmaceuticals. It does become an issue of access because hospice will screen out those with high costs, because they know that it's going to be very difficult to incur that level of expense.

I think that's a separate issue from what Jack is raising, which is in some inner-city communities pharmacies will not store

narcotics and pain meds, and therefore patients in those communities don't have access to those medications. They're two separate issues.

MR. DEBUSK: This is a question, and I was reading over the information. On page six it says for example, under the DME fee schedule, ambulatory pain pumps are reimbursed between $6,400 and $7,500 where the ASC payment for this product is $433. Are you sure that $6,400 and $7,500 is right?

MS. RAY: In the case of the ASC payment, they don't receive separate payment for the pump. I will go back and double-check my numbers. That is what our contractor gave us and she was very confident about those numbers, yes.

MR. DEBUSK: I have a hard time believing a cost to a hospital of a $200 pain pump would sell for $6,400 or $7,500. I'd like to sell those pumps.

DR. HAYES: I just have one clarifying question about Joe's thought regarding hospice, and that would be whether you would anticipate putting a mention of hospice in draft recommendation one? Would that work in this case?

The other think I would point out is that you do, of course, have another opportunity to deal with hospice issues and cost to the high end drugs that you referred to as part of the study that we'll be talking about tomorrow.

DR. NEWHOUSE: I wasn't opposed to dealing with them in both places. As for one, I guess my off the top of the head reaction is that this seems to be focused on site of care as opposed to provision at all. I would have kept it separate, but if we're going to include it -- I mean, one possibility is to say they didn't ask us about hospice here so we shouldn't have it in.

MR. HACKBARTH: Any other questions or comments? Let me ask a question about the first recommendation.

We've got big variations in the amounts that are paid for outpatient departments, ASCs, et cetera. The decisionmaker, though, about the location of the service, I would assume is usually the physician. The amount that's paid for the facility expense may or may not affect the decision that the physician makes about the appropriate location, right?

The text, at least when I read it, it sounded like there's this direct connection, if there's a difference in the facility expense and you pay more in one location than another, that all the business is going to flow that way. But to the extent that the physician is the decisionmaker, that doesn't necessarily follow, right?

DR. HAYES: The one situation I can think of where it would be a problem would be if there were let's say errors in our payments for services when they're offered in a physician's office. In which case, then the decision well may be a different setting.

MR. HACKBARTH: Clearly that's the part that's sensitive. If you're not paying the physician's costs for the facility, the office component, then obviously you're going to drive the care

elsewhere.

DR. NEWHOUSE: Plus the text here talks about the ASC itself becoming the DME supplier. And since the physician would normally be an equity owner in the ASC, it does come back to the physician.

MR. HACKBARTH: My thought was just that the discussion in the text maybe doesn't capture all of the complexity of that decisionmaking process about the location of care.

DR. HAYES: If I may, we recognize that this is a very complex problem, and that's part of the reason why this is a the secretary should evaluate type of thing. We're just trying to lay the groundwork for that kind of evaluation.

DR. NELSON: Following up on Glenn, help me understand the variability in the patient's out-of-pocket costs depending on the setting.

DR. HAYES: In the case of physician services and services provided in physicians' offices and in the case of services provided in ASCs, the coinsurance rate is 20 percent. In the case of hospital outpatient departments, the situation is much more complex. We're going through a lengthy process of the so-called buydown of beneficiary coinsurance in the hospital outpatient department. And so I guess it's fair to say that typically the copays in the outpatient department would be higher.

DR. NELSON: You may have had it here in the report, Kevin, and I've forgotten, but do you say anything or know anything about the relatively proportions of services provided? Whether most of them are provided in one or the other kind of setting? I'm trying to measure the burden on the beneficiary with this question?

DR. HAYES: We have that information and it's not in the report. Is in the contractor's report?

MS. RAY: It may be in the contractor's report. But we have that information available and we can address that issue.

DR. NELSON: I think it would be useful.

MR. HACKBARTH: Any others? Are we ready to vote?

DR. NEWHOUSE: What do you want to do with the hospice?

MR. HACKBARTH: Read what you have --

DR. NEWHOUSE: I was winging the wording, but it was something like the Secretary should investigate whether reimbursement for pain medication and hospice benefit is adequate.

DR. ROSS: Given that we already have something going on hospice, which we'll start with first thing tomorrow morning, my preference but I can't argue too strongly would be to deal with it in that setting.

DR. NEWHOUSE: I think we could there, too. There's just six months difference in when these two reports get delivered, which seems to me to be -- I don't want to push too hard.

DR. ROSS: Given the lag between recommendation and congressional action, I wouldn't worry too much about that.

DR. NEWHOUSE: In the first instance, I don't think you need Congressional action. I think you need CMS to do some investigation of what's going on.

DR. HAYES: It's not my place, Joe, to argue against doing this, but remember that in this case we are talking about a very specific group of pain management services. Those would be the interventional ones, the ones that involve, in general, threading of some kind of catheter and placement.

Now that's not to say that interventional pain management services are not provided in hospices or that they couldn't be. The one example that we've been provided with has to do with implantation of these intrathecal pumps. Just bear in mind that it's a different kind of issue than the general matter of pain medications in hospices, which are probably an important thing.

Sally points out that the other factor involved here in any kind of an assessment of payment adequacy for medications in a hospice would probably be dependant on the availability of cost report data which are coming in now, which are being assessed and so on. So I think that there's some lag built in. That's something we're confronting regardless, which may argue for Murray's comment about --

MR. HACKBARTH: Joe, given his points, I would prefer that we take it up in the context of the hospice report. Is that okay with you?

Okay, recommendation number one. All those against?

All in favor?

Abstain?

Recommendation number two. Voting no?

In favor?

Abstain?

DR. REISCHAUER: I was just holding up my hand about the use of the word "he" referring to the Secretary.

DR. ROSS: Have you met him?

DR. REISCHAUER: I'm just generally in favor of not its.

MR. HACKBARTH: Draft recommendation three. Voting no?

In favor?

Abstain?

And draft recommendation four. Voting no?

In favor?

Abstain?

Draft recommendation number five. Voting no?

In favor?

DR. ROSS: We're pending this one.

DR. LOOP: I thought we did this?

MR. HACKBARTH: We did. The only question is whether it bears reiteration in this context. And Dr. Ross, you were about to say?

DR. ROSS: I'll let you make the decision. Generally making recommendations twice I don't find particularly helpful.

MR. HACKBARTH: I would say let's not do it. If we need to make a cross-reference in the text to our recommendation, that's

fine. Okay.
Thank you very much, Nancy, Kevin.